H-1. Integrated Process Teams

The Government may develop major contract and program changes through Integrated Process Teams (IPTs). This clause describes the contractor's participation in this process. The contractor shall provide the appropriate personnel (as agreed to by the Contracting Officer and the contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any and all proposed TRICARE program contract changes within 14 calendar days after notification by the Contracting Officer. The contractor will participate in the entire process with the Government team from concept development through incorporating the change into the contract. This process includes developing budgetary cost estimates, requirement determination, developing rough order of magnitude cost estimates, preparing specifications/statements of work, and establishing a mutually agreeable equitable adjustment to the contract price as a result of incorporating the change (including pricing, negotiations, etc). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The contractor shall participate in all required meetings as determined by the Government team leader, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences within the TMA web site). The frequency and scheduling will vary depending on the topic.

H-2. Performance Guarantee

H-2.1. The performance guarantee described in this clause is the contractor's guarantee that the contractor's performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee clause are in accordance with, and in addition to all other rights and remedies of the Government. Specifically, the Government reserves its rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4) and the Default clause (FAR 52.249-8).

H-2.2. The contractor guarantees that performance will meet or exceed the standards in this clause. For each occurrence the contractor fails to meet each guaranteed standard, the Government will withhold from the contractor the amount listed in the schedule below. Performance guarantee withholds will continue until the guarantee amount for the respective option period is depleted or the contractor's performance improves to meet or exceed the standard. Performance will be measured as specified below. The contractor will be notified and withholds made on a quarterly basis. For the purposes of this clause, the term "performance standard" is defined as the contract standards that are restated in this clause.

H-2.3. Performance Guarantee Amounts:

Option Period I $_____

Option Period II $_____

Option Period III $_____

Option Period IV $_____

Option Period V $_____

H-2.4. Telephone Service (Busy Signals)

H-2.4.1. Standard: Not less than 95% of all calls shall be received without the caller encountering a busy signal.

H-2.4.2. A performance guarantee shall be applied as follows:

H-2.4.2.1. Based on the contractor's monthly report, the Government will withhold a performance guarantee amount of $0.50 per blocked call in excess of the standard (not less than 95% of all calls shall be received without the caller encountering a busy signal). For example, if 92% of calls are received but 8% are blocked by a busy signal, then a

performance guarantee equal to 3% of the calls [the difference between the actual of blocked calls (8%), and the percentage allowable under the standard (5%)] will be assessed. If 3% equates to 100 calls, the performance guarantee withhold will be $50.00 or 100 times $0.50. The blockage rate shall be determined no less frequently than once per hour.

H-2.4.2.2. All calls is defined as any call to any contractor operated TRICARE customer service telephone number. Customer service shall be interpreted in the broadest terms including telephone calls from beneficiaries, providers, Government representatives, and interested parties about general program information, network providers, enrollment, eligibility, benefits, referrals, preauthorizations/authorizations, claims, complaints, processes and procedures.

H-2.5. Telephone Service (Total Hold Time)

H-2.5.1. Standard: 100% of all calls shall not be on hold for a period of more than 30 seconds during the entire telephone call

H-2.5.2. A performance guarantee shall be applied as follows:

H-2.5.2.1. If performance falls below the standard for each individual call that has a total hold time of more than 30 seconds based on the contractor's monthly report, the Government will withhold a performance guarantee amount of $0.50. For example, if only 97% of calls that have a total hold time of 30 seconds or less, the actual number of calls failing the 100% standard will be assessed a performance guarantee. In this example, the difference equals 3%. If 3% of calls equates to 100 calls not meeting the 30 second total hold time standard, the performance guarantee withhold will be $50.00 or, 100 times $0.50.

H-2.6. Claims Processing Timeliness (Retained Claims and Adjustment Claims)

H-2.6.1. Standard: Not less than 95% percent of retained claims and adjustment claims processed shall be completed within thirty (30) calendar days from the date of receipt.

H-2.6.2. A performance guarantee shall be applied as follows:

H-2.6.2.1. If the contractor fails to meet the standard of 95%, the Government will withhold a performance guarantee amount of $1.00 per retained claim not meeting the standard. For example, if only 91% of retained claims are processed within 30 calendar days, a performance guarantee will be assessed equal to 4% of the claims processed that month. The 4% represents the difference between the actual performance of 91% and the standard of 95%. If 4% equates to 600 claims, the performance guarantee withhold will be $600.00 or 600 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

H-2.7. Claims Processing Timeliness (Retained Claims)

H-2.7.1. Standard: 100% of retained claims shall be processed to completion within sixty (60) calendar days.

H-2.7.2. A performance guarantee shall be applied as follows:

H-2.7.2.1. If the contractor fails to meet the standard of 100% of retained claims processed to completion within 60 days, the Government will withhold a performance guarantee amount of $1.00 per retained claim not meeting the standard. For example, if actual performance is 99% of retained claims processed to completion within 60 days, the contractor will be assessed a performance guarantee equal to 1% (the difference between the contractor's actual performance and the standard. If 1% equates to 100 claims, the withhold will be $100.00, or 100 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

H-2.8. Claims Processing Timeliness (Excluded Claims)

H-2.8.1. Standard: 100% of all claims shall be processed to completion within 120 calendar days.

H-2.8.2. A performance guarantee shall be applied as follows:

H-2.8.2.1. If the contractor fails to meet the standard and falls below the standard of all claims processed to completion within 120 calendar days, the Government will withhold a performance guarantee amount of $1.00 per claim not meeting the standard. For example, if 1% (the difference between the contractor's actual performance and the standard) of all claims are not processed to completion within 120 calendar days from the date of receipt, and that equates to 1,000 claims, the performance guarantee amount will be $1,000.00 or, 1,000 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database. The Government will assess a performance guarantee amount monthly until the claim is processed to completion.

H-2.9. Payment Errors

H-2.8.1. Standard: The absolute value of the payment errors for sampled TEDs (initial submissions, re-submissions, and adjustments/cancellation submissions) shall not exceed 2% (reference H.3.1.1.1).

H-2.9.2. A performance guarantee shall be applied as follows:

H-2.9.2.1. If payment errors exceed the standard, the Government will withhold 10% of the value of payment errors exceeding the 2% standard. The Government will not net errors as a result of overpayments and underpayments. Rather, the Government will withhold a performance guarantee amount equal to 10% of the sum of all payment errors in excess of the standard. This amount will be based on the actual claims audited in the quarterly TMA audits as specified in the Claim Audit clause in Section H.

H-2.10. TED Edit Accuracy – Validity Edits

H-2.10.1. Standard: The accuracy rate for TED validity edits shall be not less than: 93 % after six months of performance during the first option period and 98 % after nine months and thereafter during the entire term of the contract.

H-2.10.2. A performance guarantee shall be applied as follows:

H-2.10.2.1. If the contractor fails to meet the standard and falls below either of the two standards of 93 % after six months or 98 % after nine months, a performance guarantee amount of $1.00 for each TED record not meeting the standard will be withheld. For example, if only 90% of all TEDs pass validity edits after six months, then a performance guarantee amount equal to 3% of all TEDs failing the edits during the quarter will be withheld (3% equals the difference between the contractor's actual performance and the standard in this example). If 3% equates to 1,000 TEDs, the performance guarantee amount will be $1,000.00 or 1,000 times $1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

H-2.11. TED Edit Accuracy – Provisional Edits

H-2.11.1. Standard: The accuracy rate for provisional edits shall not be less than: 88 % after six months of performance during the first option period and 94 % after nine months and thereafter during the entire term of the contract

H-2.11.2. A performance guarantee shall be applied as follows:

H-2.11.2.1. If the contractor fails to meet the standard and falls below either of the two standards of 88 % after six months or 94 % after nine months, a performance guarantee amount of $1.00 for each TED not meeting the provisional edit standard will be withheld. For example, if only 85% of all TEDs pass provisional edits after six months, a performance guarantee equal to 3%, or the difference between the contractor's actual performance and the standard, will be assessed. If, as in this example, 3% equates to 1,000 TEDs, the performance guarantee will be $1,000.00 or 1,000 times $1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

H-3. Claim Cycle Time and Audit Methodology

H-3.1. Claim Cycle Time Measurement.

The Government will calculate the claim cycle time based on data submitted on TRICARE Encounter Data (TEDs). The cycle time is calculated as one plus the difference between the Julian date that the claim or adjustment claim was processed to completion and the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single cycle time will be calculated per claim. This cycle time will be calculated using all unedited TEDs initial submission vouchers (Voucher Resubmission Number equals zero) which are received by TMA during each quarter and which pass the voucher header edits. TEDs in vouchers which fail the voucher header edits or which are otherwise unprocessable as submitted by the Contractor and TEDs in resubmission vouchers (Voucher Resubmission Number is greater than zero) will be excluded from the claim cycle time calculation.

H-3.1.1. Claim Audit Sampling and Error Determinations.

H-3.1.1.1. Sampling Methodology. Sample means will be used as point estimates of payment and occurrence errors. There will be two kinds of payment samples, one for non-denied claims and one for denied claims. The design of non-denied payment and the occurrence samples utilizes a ninety percent (90%) confidence level, while the denied payment sample design uses an eighty percent (80%) confidence level. Precision estimates are 1.0 percent (1%) for the non-denied payment sample, 2.0 percent (2%) for the denied payment sample, and 1.5 percent (1.5%) for the occurrence sample. The non-denied payment sample will be drawn from all records with government payments of $ 1.00 to $ 25,000. In addition, all records with a government payment of $ 25,000 and over will be audited. The denied payment sample will be drawn from all records with billed amounts of $ $1.00 to $ 500,000. In addition, all records with billed amounts of $500,000 and over will be audited. The non-denied payment sample will be stratified at multiple levels within the $ 1.00 to $ 25,000 range and the denied payment sample will be stratified at multiple levels within the $1.00 to $500,000 range. Samples will be drawn on a quarterly basis from TEDs which pass TMA validity edits. Records to be sampled will be “net” records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers which fail TRICARE validity edits or which are otherwise unprocessable as submitted by the Contractor will be excluded from the sampling frame.

H-3.1.1.2. Required Contractor Documentation.

H-3.1.1.2.1. Upon receipt of the TEDs Internal Control Number (ICN) listing from TMA or designated audit contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service. All documentation must be received at TMA or designated audit contractors within thirty (30) calendar days from the date of the TMA or designated audit contractors letter transmitting the ICN listing:

H-3.1.1.2.1.1. Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.

H-3.1.1.2.1.2. Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate or fee schedule and such other documents as are required to support the action taken on the claim.

H-3.1.1.2.1.3. A copy of the EOB (or EOB facsimile) for each claim selected.

H-3.1.1.2.1.4. The contractor shall send via electronic data input on a 3480 cartridge the current family history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or designated audit contractor within thirty (30) calendar days from the date of the TMA or designated audit contractor letter transmitting the ICN listing.

H-3.1.1.2.2. Payment errors or occurrence errors will be assessed if the Contractor does not provide the above claim-related documents or if the documents provided are not legible. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit contractors will return original documents upon completion of the audit process.

H-3.1.1.3. Additional Data to be Furnished by the Contractor.

H-3.1.1.3.1. Description of data elements by field position in family history file printout. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

H-3.1.1.3.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

H-3.1.1.3.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the fifth (5th) work day of the month following the change.

H-3.1.1.3.4. Specifications for submission of the provider and pricing files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

H-3.1.1.4. Payment Error and Process Error Determinations.

H-3.1.1.4.1. There are two categories of payment errors: (1) a payment error which cannot be removed by Contractor post payment processing actions and (2) a payment error which can removed by Contractor post payment processing actions (see list of audit error codes defining payment error categories). Payment errors which can be removed by Contractor post payment actions will also be assessed a process error at audit. If Contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

H-3.1.1.4.2. Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a noncovered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity review not evident and are cited in conjunction with a payment error . Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

H-3.1.1.4.3. Payment errors which may not be removed by Contractor post payment actions (see audit error categories) are based only on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled. Actions and determinations occurring subsequent to the date the audit sample is pulled or actions and determinations which have not passed the TMA TED Validity edits are not a consideration of the audit regardless of whether resolution of a payment error results. Because adjustment transactions are not allowed on total claim denials, subsequent reprocessing actions to the denied claim which occur prior to the date the audit sample is pulled will be considered during the audit.

H-3.1.1.4.4. The measure of the payment error is the TED record. The audit process (for the payment samples) projects universe value based on the audit results. The samples (non-denied and denied) are separately projected to the universe of claims for each quarter. The results of these projections are then combined into the following categories: total number of claims in the universe, government payment estimation, correct government payment, error amount and the estimated error percent in the universe of claims.

H-3.1.1.4.5. All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

H-3.1.1.5. Computation of the “Total Amount Billed” for Denied Claims.

H-3.1.1.5.1. For treatment encounters for which no per diem, negotiated rate or DRG-based amount applies for consideration of payment, the “total amount billed” is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG-exempt services and

those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid;

H-3.1.1.5.2. For treatment encounters subject to the TRICARE per diem payments, negotiated rate, or the DRG-reimbursement methodology, the "total amount billed" is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

H-3.1.1.5.3. If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total amount billed will be assessed. For health care services records which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total amount billed. This condition is considered to be an unsupported TED.

H-3.1.1.6. TED Occurrence Error Determination.

H-3.1.1.6.1. The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

H-3.1.1.6.2. Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields, or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

H-3.1.1.6.3. Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

H-3.1.1.6.4. Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated below:

H-3.1.1.6.5. Following are error conditions and the associated number of occurrence errors assessed with each condition; payment error codes that post payment actions do not apply; payment error codes that post-payment actions do apply, and process error codes.

ERROR CONDITION	NUMBER OF ERRORS
Unlike Procedures/Providers Combined (Noninstitutional Record)	7 errors for each additional utilization data set*
Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**
Services Should Be Combined	1 error for each additional revenue code/utilization data set
Missing Noninstitutional Utilization Data Set	7 errors for each missing data set*
Extra Noninstitutional Utilization Data Set	7 errors for each extra data set*
Missing Institutional Revenue Code Set	5 error for each missing revenue code set**
Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
Incorrect Record Type	5 errors
Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
Claim Not Auditable	1 error plus 1 error for each revenue code utilization data set in the TED
Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in the TED

* Not to exceed 21 errors for combination of these error conditions.
** Not to exceed 15 errors for combination of these error conditions.

H-3.1.1.6.6. The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

01K-Authorization *I* PreAuthorization Needed (all — except PFTH and Adjunctive Dental Authorizations)
03K-Billed Amount Incorrect
04K-Cost-share *I* Deductible Error
07K- Duplicate Services Paid
08K- Eligibility Determination — Patient
09K- Eligibility Determination — Provider
12K- Non-Availability Statement Error
13K-OHI/TPL — Govt. Pay Miscalculated

16K- Payee Wrong- Provider
17K- Participating/Non-Participating Error
18K- Pricing Incorrect
19K-Procedure Code Incorrect
20K-Signature Error
22K- DRG Reimbursement Error
24K-Incorrect Benefit Determination
25K-Claim Not Provided
26K-Claim Not Auditable
27K-Incorrect MCS System

H-3.1.1.6.7. The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

01K-Authorization/Pre-Authorization Needed (PFTH and adjunctive dental authorizations)
02K-Unsupported Benefit Determination
05K-Development Claim Denied Prematurely
06K-Development Required
10K-Medical Emergency Not Substantiated
11K-Medical Necessity/Review Not Evident
21K-Timely—Filing Error
23K-Contract Jurisdiction Error
99K-Other. This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

H-3.1.1.6.8. The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors or payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

01 P — Authorization/Pre-authorization needed (PFTH arid dental authorizations)
02P — Unsupported Benefit Determinations
05P — Development Claim Denied Prematurely
06P — Development Required
l0P - Medical Emergency Not Substantiated
l1P — Medical Necessity/Review Not Evident
21 P — Timely Filing Error
23P — Contract Jurisdiction Error
99P—Other

H-3.1.2. Error Determination Rebuttals:

H-3.1.2.1. Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality audit within forty five *(45)* calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within forty five *(45)* calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit contractor during the initial rebuttal process must be postmarked within thirty (30) calendar days of the TRICARE or designated quality review contractor rebuttal response letter. Rebuttals to new errors not postmarked within thirty (30) calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding forty five (45) to the Julian calendar date of the TMA or designated audit contractor audit letter or by adding thirty (30) to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.